UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SOMAVERT (pegvisomant)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** acromegaly.
- **DOCUMENTATION** showing inadequate response to either transsphenoidal adenomectomy or radiotherapy or both.
- **DOCUMENTED** trial on at least one Dopamine agonist such as cabergoline (Dostinex) or bromocriptine.
- **DOCUMENTATION** that patient has been evaluated for a somatostatin analogue such as octreotide acetate (sandostatin).

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

8/8/6